Physician Fraud and Abuse

Why look at physicians (doctors)?

- People trust their doctors (Most physicians are honest, and not fraudulent providers).

- Only doctors can decide what services, supplies and equipment are **"medically necessary"** or fill out a Certificate of Medical Necessity (CMN).

- Elderly patients or patients with disabilities can be particularly vulnerable to physician fraud and abuse

- People are reluctant to question their doctor because they are afraid of a negative impact on their care or that the doctor will no longer treat them. Many people, especially seniors, may be intimidated by the healthcare system in general, often failing to voice concerns or ask the questions they have about care and services, deferring to the "experts".

What is a kickback?

A kickback is an arrangement between two parties which involves an offer **to pay for** Medicare business. Kickbacks generate extra business for the participants and unneeded services for the patients. They also drain scarce tax dollars. Health care providers engaging in kickback activities are subject to criminal prosecution and exclusion from the Medicare and Medicaid programs.

Kickback examples involving physicians:

- Paying a fee to a physician for referrals to home health or hospice agencies, nursing homes, etc.,

- Paying a fee to a physician for each patient care plan certified by the physician on behalf of a home health or hospice agency, nursing home, etc., and

- Paying beneficiaries $50 each time they receive **"treatment"** at a clinic.

Fraud schemes:

- Physicians may falsify Certificates of Medical Necessity (CMNs).

- **Recruiters** may find beneficiaries at seniors' gatherings, or knock on doors in a senior housing area, and offer money or promotional gifts as incentives to entice the beneficiary to have a medical examination. In some cases, these recruiters seek the beneficiaries' Medicare numbers in exchange for some "free" gift, such as a case of nutritional supplement.

- **Physicians may work together to share beneficiaries.** They refer patients for additional services to other physicians to share the bills they can charge Medicare for unnecessary and/or phony treatments. [This does not include the Health Maintenance Organization (HMO) that works with a group of specific doctors for patient care.]

- Physicians who visit nursing homes may bill for comprehensive physical examinations without ever seeing the resident or falsify medical records to indicate that nonexistent services were rendered.

- Psychiatrists may conduct group sessions in a nursing home or long-term care facility and bill for individual therapy.

- **UPCODING** – Altering claim forms to obtain a higher payment amount (**for example**, charging for a surgical procedure in place of applying a bandage to a wound).

- **UNBUNDLING** services (**for example**, billing laboratory tests separately to charge a higher amount than if they are combined and billed as one service)

Billing non-covered services as a covered service:

For example, a doctor bills acupuncture (non-covered) as physical therapy or joint injections (covered services).

For example, a podiatrist provides routine toenail clipping, which is a non-covered service, and bills Medicare for a more expensive covered service. Routine foot care is only covered if there is some underlying medical condition warranting professional services.

For example, an ophthalmologist performs a routine eye exam, but bills Medicare as if another type of exam were provided. Medicare does not cover routine eye exams.

For example, laser eye surgery is a common billing problem with ophthalmologists. Was it medically necessary? Was it really performed? One ophthalmologist falsified documentation for a test used to establish the need for cataract surgery. He performed more than 100 unnecessary surgeries and billed Medicare.

- **Billing non-covered services as covered services:**

For example, billing for a case of the flu instead of a routine physical examination

For example, billing for experimental procedures and nonexistent treatment

For example, an allergist used phony progress notes to back up bogus claims for allergy tests. He also ordered his staff to randomly select 13-15 patient files per week and create “phantom” bills for services that were never performed, and to back up those claims with fabricated test results and progress notes.

Billing for unnecessary procedures:

For example, in August 2003 Tenet Healthcare, the second-largest for-profit hospital chain in the nation, agreed to pay $54 million to settle allegations that two physicians at Tenet-owned Redding Medical Center in California participated in a "scheme to cause patients to undergo unnecessary invasive coronary procedures," such as artery bypass and heart valve replacement surgeries in order to defraud Medicare. This is the largest settlement recovered from a hospital in a case related to alleged unnecessary surgeries or other medical services. [1]

For example, an ophthalmologist was charged with Health Care Fraud in Connection with Adult Mental Homes in New York because he "repeatedly took advantage of mentally ill residents by performing unnecessary" surgeries and sought reimbursement for services that he never administered. [2]

U.S. Attorney James Comey said, "Doctors who exploit patients with disabilities solely to satisfy their own greed through Medicare and Medicaid fraud will be vigorously prosecuted."[3]

Things to look for:

- Statements by beneficiaries that no physician was present at any time during the service or procedure, or that he/she has never seen the physician/practitioner

- Payments (in cash or kind) in return for providing your Medicare Health Insurance Claim Number or for visiting a clinic or office

- Review Explanation of Medicare Benefits (EOMB) or Medicare Summary Notice (MSN) to ensure that the services billed match the services that were provided.

[1] Los Angeles Times (8/7/03); Kaiser Daily Health Policy Report (11/1/02).
[2] New York Times (1/7/03).

- Be suspicious if a doctor tells you that the equipment, service or test is free. It won't cost you anything. **MEDICARE DOES NOT PROVIDE ANYTHING FOR FREE!** People on Medicare pay with higher premiums. All of us pay through tax increases.

It is in your best interest and that of all citizens to report suspected fraud. Health care fraud, whether against Medicare, Medicaid or private insurers, increases everyone's health care costs, much the same as shoplifting increases the costs of the food we eat and the clothes we wear. If we are to maintain and sustain our current health care system, we must work together to reduce costs.

To Report Suspected Medicare or Medicaid Fraud
Call Toll-free 1-866-726-2916
Or Write to Address Below

DHHS – Division of Aging & Adult Services (501) 682-8504
700 Main Street, P.O. Box 1437, Slot S530 **1-866-726-2916**
Little Rock, AR 72201-1437 *sharon.marcum@arkansas.gov*